N323 Care Plan

Lakeview College of Nursing

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Demographics (3 points)

Date of Admission 3/27/21	**Patient Initials** D.B.	**Age** 44 years old	**Gender** Male
Race/Ethnicity Caucasian	**Occupation** Nurse	**Marital Status** Single	**Allergies** Statins, Quetiapine, Hydromorphone, Latex, Zolpidem
Code Status Full Code	**Observation Status** Every 15 minutes	**Height** 5'6"	**Weight** 190 lbs

Medical History (5 Points)

Past Medical History: Involuntary movement disorder, asthma, gastroesophageal reflux disease, high blood pressure, hyperlipidemia, and sleep apnea.

Significant Psychiatric History: The client's psychiatric history began in 2004. He stated that he was hospitalized twenty-three times between 2004-2006. These hospitalizations were due to anxiety, depression, suicidal thoughts, and suicide attempts. The client stated that enrolling in nursing school in 2011 helped his mental health immensely. He stated that he didn't feel debilitating anxiety or depression again until October 2020. In October, his anxiety began to feel overwhelming, and he felt significantly depressed. He has been hospitalized several times since October for self-harm and suicidal thoughts. The patient has also been diagnosed with bipolar affective disorder.

Family History: Mother had breast cancer and passed away in 2002. Father has Parkinson's disease. Patient suspects his sister may have depression, but his family doesn't discuss mental health.

Social History (tobacco/alcohol/drugs): Patient states he doesn't drink alcohol, smoke, or use non-prescription drugs.

Living Situation: Patient lives alone in a rented house.

Strengths: Patient stated that his strengths include caring about others and having good skill sets with work and music.

Support System: The patient states that he is very close with his sister and visits his father regularly but doesn't want to talk about his mental health with his family. He states that he doesn't want to burden them. He also has support with friends and coworkers that have been sending him uplifting messages and check in on him. When he leaves OSF he is going to participate in a Partial Hospitalization Program (PHP) in which he will go to the hospital during the day and attend group therapy and return home in the evening.

Admission Assessment

Chief Complaint (2 points): The client's chief complaint upon admission was overwhelming anxiety.

Contributing Factors (10 points): Factors that lead to admission: The patient expressed that his anxiety began to build throughout the week. He had tried to call his therapist but was unable to speak with him. He stated that he "wasn't sure if he could make it through the weekend without knowing he had support if something went wrong." The patient stated he took "eight or nine pills to feel better." He was brought to the emergency department due to taking too much medication. While in the emergency department he became frustrated with the staff and physicians. He stated that he felt like they weren't listening to his concerns. Out of frustration, the patient used a plastic fork to cut his wrist. D.B. stated that he wasn't trying to commit suicide, he was using cutting as an outlet to relieve his anxiety. A major contributing factor to his depression is his ineffective coping skills with his mother's death.

History of suicide attempts: The patient admitted to two attempted suicides in 2004 and 2006. He denies any recent suicide attempts.

Primary Diagnosis on Admission (2 points): The patient was diagnosed with unspecified depressive disorder, general anxiety disorder, and bipolar affective disorder.

Psychosocial Assessment (30 points)

History of Trauma				
No lifetime experience: **Witness of trauma/abuse:**				
	Current	**Past (what age)**	**Secondary Trauma (response that comes from caring for another person with trauma)**	**Describe**
Physical Abuse	None	Childhood (Grade school)	None	The patient stated that he was bullied severely in grade school by other kids. He refused to discuss a specific details.
Sexual Abuse	None	Unsure	None	The patient denied sexual abuse during our conversation but paused many

				times, leading me to believe that he may have been. His chart has conflicting notes about sexual abuse but in both he refused to go into detail about the incidents.
Emotional Abuse	2015	Childhood (Grade school)	None	The patient stated that he was bullied severely in grade school by other kids. He refused to discuss a specific details. The patient stated that at work in 2015 there was a coworker that would make up stories about him, try to get him in

				trouble, and ridicule him.
Neglect	None reported	None reported	None	N/A
Exploitation	None reported	None reported	None	N/A
Crime	None reported	None reported	None	N/A
Military	None reported	None reported	None	N/A
Natural Disaster	None reported	None reported	None	N/A
Loss	None reported	Mother in 2002	None	The patient stated that he is unable to move past the grief stage of grieving. He stated that he feels guilty that he didn't spend enough time with her when she was sick.
Other	None reported	None reported	None	N/A

Presenting Problems			
Problematic Areas	**Presenting?**		**Describe (frequency, intensity, duration, occurrence)**
Depressed or sad mood	**Yes**	**No**	The patient noted that he was sad that he self-harmed and put himself in the situation he is in.
Loss of energy or interest in activities/school	**Yes**	**No**	N/A

Deterioration in hygiene and/or grooming	**Yes**	**No**	N/A
Social withdrawal or isolation	**Yes**	**No**	N/A
Difficulties with home, school, work, relationships, or responsibilities	**Yes**	**No**	Patient has been off work since November 2020 due to his anxiety and depression.
Sleeping Patterns	**Presenting?**		**Describe (frequency, intensity, duration, occurrence)**
Change in numbers of hours/night	**Yes**	**No**	The patient stated he doesn't sleep well at home.
Difficulty falling asleep	**Yes**	**No**	The patient tries to fall asleep but is unable to.
Frequently awakening during night	**Yes**	**No**	He wakes up multiple times at night.
Early morning awakenings	**Yes**	**No**	Patient states he usually gets up early in the morning after not getting enough sleep throughout the night.
Nightmares/dreams	**Yes**	**No**	N/A
Other	**Yes**	**No**	N/A
Eating Habits	**Presenting?**		**Describe (frequency, intensity, duration, occurrence)**
Changes in eating habits: overeating/loss of appetite	**Yes**	**No**	Patient states he is often not hungry, or his anxiety causes his stomach to hurt.
Binge eating and/or purging	**Yes**	**No**	N/A
Unexplained weight loss? **Amount of weight change:**	**Yes** **50 lbs weight** **loss since** **November**	**No**	Patient stated he wanted to lose some weight but feels the way he lost this weight was unhealthy.
Use of laxatives or excessive exercise	**Yes**	**No**	N/A
Anxiety Symptoms	**Presenting?**		**Describe (frequency, intensity, duration, occurrence)**

Anxiety behaviors (pacing, tremors, etc.)	**Yes**	**No**	Frequent manifestations of anxiety. Continuous movement, pacing.
Panic attacks	**Yes**	**No**	N/A
Obsessive/compulsive thoughts	**Yes**	**No**	N/A
Obsessive/compulsive behaviors	**Yes**	**No**	N/A
Impact on daily living or avoidance of situations/objects due to levels of anxiety	**Yes**	**No**	N/A
Rating Scale			
How would you rate your depression on a scale of 1-10?			The patient states his depression is a 5 because he wants to get home and get back to work.
How would you rate your anxiety on a scale of 1-10?			Patient states his anxiety is a 3 right now.
Current Stressors of Areas of Life Affected by Presenting Problem (work, school, family, legal, social, financial)			
Problematic Area	**Presenting?**		**Describe (frequency, intensity, duration, occurrence)**
Work	**Yes**	**No**	The patient states that "He loves his job but working overnight and taking care of people can add to his anxiety, especially on bad nights."
School	**Yes**	**No**	N/A
Family	**Yes**	**No**	N/A
Legal	**Yes**	**No**	N/A
Social	**Yes**	**No**	N/A
Financial	**Yes**	**No**	The patient explained that he has used all of his paid time off and sick leave at work. He has short-term disability, but it is running out soon. The idea of his short-term disability running out causes him anxiety frequently.
Other	**Yes**	**No**	N/A

Previous Psychiatric and Substance Use Treatment – Inpatient/Outpatient				
Dates	**Facility/MD/ Therapist**	**Inpatient/ Outpatient**	**Reason for Treatment**	**Response/Outcome**
November 10th 2020	**Inpatient** OSF Peoria **Outpatient Other:**	Inpatient	Anxiety attack, chest tightness, shortness of breath.	**No improvement** **Some improvement** **Significant improvement**
February 2021	**Inpatient** Chicago **Outpatient Other:**	Inpatient	Patient was experiencing suicidal thoughts and having hallucinations.	**No improvement** **Some improvement** **Significant improvement**
First week of March 2021	**Inpatient** OSF Peoria **Outpatient Other:**	Inpatient	Patient was experiencing suicidal thoughts. He voluntarily took himself to the emergency department and surrendered his cutting supplies and rope.	**No improvement** **Some improvement** **Significant improvement**

Personal/Family History				
Who lives with you?	**Age**	**Relationship**	**Do they use substances?**	
Client lives alone in a rented home.	N/A	N/A	**Yes**	**No**
If yes to any substance use, explain: Client doesn't use alcohol or drugs. Only uses medication prescribed to him.				
Children (age and gender): Client has one daughter, 22 years old. She recently moved to				

Colorado.

Who are children with now? N/A

Household dysfunction, including separation/divorce/death/incarceration:

No current household disfunction.

Current relationship problems: No current relationship problems. Client isn't dating anyone.

Number of marriages: 0

Sexual Orientation: **Straight**	**Is client sexually active?** **Yes** **No**	**Does client practice safe sex?** **Yes** **No**

Please describe your religious values, beliefs, spirituality and/or preference:

Client stated that he grew up going to church and described himself as spiritual. He is not currently attending church but said his friends invite him to go often.

Ethnic/cultural factors/traditions/current activity: Current activity.

Describe: The patient expressed that he wants to get back to work and, in a routine, again.

Current/Past legal issues (with self/parents, arrests, divorce, CPS, probation officers, pending charges, or course dates): N/A

How can your family/support system participate in your treatment and care?

The patient is close with his sister and father but stated multiple times that he doesn't want to discuss his mental health with his family. When asked why he doesn't want to talk with his family he states that he doesn't want to burden them and "They just don't talk about stuff like that."

Client raised by:

Natural parents
Grandparents
Adoptive parents
Foster parents
Other (describe):

Client described his home life growing up as a loving home. He was very close with his

mother because his father worked a lot.

Significant childhood issues impacting current illness:

Client was physically and emotionally abused through much of his grade school and high school. He didn't want to open up about what happened specifically, but it had a strong impact in his life.

Atmosphere of childhood home:

Loving
Comfortable
Chaotic
Abusive
Supportive
Other:

Patient stated his home life growing up was loving. He stated that his older brother sometimes picked on him, but he knew his brother loved him.

Self-Care:

Independent
Assisted
Total Care

The patient is able to complete ADL's independently without assistance.

Family History of Mental Illness (diagnosis/suicide/relation/etc.)

Unconfirmed family history of mental illness. Patient expressed that he believes his sister might deal with depression. He also stated that his father is depressed due to his illness of Parkinson's disease.

History of Substance Use: The patient doesn't drink alcohol or do drugs other than prescription medication prescribed to him.

Education History:

Grade school
High school

College **Other:** Patient has a BSN degree.
Reading Skills: **Yes** **No** **Limited**
Primary Language: English
Problems in school: No problems in nursing school besides “The usual stress with nursing school.” Patient did experience significant bullying in grade/high school.
Discharge
Client goals for treatment: The client’s goals are centered around being able to return to work soon. He is going to participate in PHP and continue therapy. He is very motivated to get back to work.
Where will client go when discharged? The patient will return to his home upon discharge but will attend a partial hospitalization during the day for a few weeks.

Outpatient Resources (15 points)

Resource	Rationale
1. Adult Partial Hospitalization Program at Methodist (PHP) https://www.unitypoint.org/peoria/adult-partial-hospitalization-program-at-methodist-php.aspx	**1.** Goals of this program include helping clients to improve their coping skills, make positive life choices, and provide support. A trigger of D.B.'s anxiety is feeling that he has to go a few days without help if he needs it.
2. Illinois Warm Line 866-359-7953	**2.** Specialists offering support in this program have also experienced behavioral health issues in their own life. The patient could benefit from working through issues with the help of someone who has experienced a similar situation.
3. Illinois Call4Calm Text Line (24/7) Text TALK to 552020	**3.** This program offers an anonymous feature while connecting the client to a counselor and local resources. This could be good for the patient if he wants to reach out but wants to remain anonymous due to feeling embarrassed.

Current Medications (10 points)
Complete all of your client's psychiatric medications

Brand/Generic	**Cogentin/ benztropine mesylate**	**Depakote/ divalproex sodium**	**Haldol/ haloperidol**	**Atarax/ hydroxyzine hydrochloride**	**Desyrel/ trazodone**
Dose	2 mg	250 mg	5 mg	25 mg	50 mg
Frequency	Twice daily as needed	Twice daily	Every 4 hours as needed	Twice daily	Once at night
Route	Oral or IM	Oral	Oral or IM	Oral	Oral
Classification	Antiparkinsonian central-acting anticholinergic	Anticonvulsant	Antidyskinetic, antipsychotic	Antianxiety	Antidepressant
Mechanism of	Blocks	Blocks	Blocks	Competes with	Blocks

Action	acetylcholine at receptor sites. This restores the dopamine and acetylcholine balance.	reuptake of GABA. GABA suppresses rapid firing of neurons.	postsynaptic dopamine receptors and increases turnover of dopamine.	histamine for receptor sites. Sedative actions occur at subcortical level of central nervous system.	serotonin reuptake causing an antidepressant effect.
Therapeutic Uses	To treat dystonic reactions.	To treat bipolar disorder. Treats seizure disorder.	To treat psychotic disorders.	Treat anxiety.	To treat major depressive disorder.
Therapeutic Range (if applicable)	0.5 to 6 mg	40-150 mcg/ ml	10-50 ng/ml	N/A	200-600 mg/ dl
Reason Client Taking	To treat tremors that may occur with the use of Haldol.	Prevent manic episodes.	To treat bipolar disorder.	Treat anxiety.	Treat depression.
Contraindications (2)	Bladder neck obstruction. Glaucoma.	Hepatic impairment. Urea cycle disorders.	Coronary artery disease. Bone marrow depression.	Hypersensitivity to cetirizine or hydroxyzine. Prolonged QT interval.	Recovery from acute MI. Use of MAOI within 14 days.
Side Effects/Adverse Reactions (2)	Blurred vision. Flushing.	Hallucinations. Bradycardia.	Cardiac arrest. Acute hepatic failure.	Dry mouth. Involuntary motor activity.	Abnormal coordination. Memory impairment.
Medication/ Food Interactions	Give before or after meals. Before if patient has dry mouth. After if patient has increased saliva secretions.	Alcohol: CNS depression. Tricyclic antidepressants: increased CNS depression, lowered seizure threshold. NSAIDS and aspirin: bleeding risk.	Fluoxetine, buspirone: Increased plasma haloperidol concentration. CNS depressants: increased CNS depression and hypotension. MAOI, tricyclic antidepressants: increased sedation.	Antibiotics such as azithromycin; antidepressants such as citalopram; antipsychotics such as clozapine: increased risk for QT prolongation. CNS depressants: Increased CNS depression. Alcohol: increased CNS depression.	Aspirin and NSAIDS: increased risk of bleeding. CNS depressants: enhanced CNS depression. MAOI: increased serotonin effects. Warfarin: altered anticoagulation response. Alcohol:

			Alcohol: increased CNS depression, hypotension, and respiratory depression.		Increased CNS depression, hypotension, respiratory depression.
Nursing Considerations (2)	Stress the need for eye examinations and intraocular pressure measurements. Monitor patient for adverse reactions and overdose.	Monitor ammonia levels and liver function tests. Watch patients closely for suicidal tendencies.	Avoid stopping abruptly. Instruct patient to report tremors and vision changes.	Don't give by subcutaneous or IV route due to possibility of tissue necrosis. Use cautiously in patients with bradyarrhythmia.	Give with meal or snack to reduce nausea. Give in the evening due to drowsiness effect.

Brand/Generic	**Protonix/ pantoprazole**	**Zofran/ Ondansetron hydrochloride**	**Tylenol/ acetaminophen**	**NicoDerm CQ/ nicotine transdermal patch**
Dose	40 mg	4 mg	650 mg	21 mg
Frequency	Once daily	Every 8 hours as needed	Every 4 hours as needed	24-hour patch
Route	Oral	Oral	Oral	Transdermal
Classification	Antiulcer, gastric acid proton pump inhibitor	Antiemetic	Antipyretic. Nonopioid analgesic.	Smoking cessation adjunct.
Mechanism of Action	Inhibits the secretion of gastric acid by interfering with the hydrogen-potassium-adenosine-triphosphatase enzyme system.	Blocks serotonin receptors centrally in the chemoreceptor trigger zone and peripherally at vagal nerve terminals in the intestine. This action reduces nausea and vomiting by preventing	Inhibits the enzyme cyclooxygenase, blocking prostaglandin production and interfering with pain impulse generation in the peripheral nervous system. Acetaminophen also acts directly	Binds to nicotine receptors in the brain.

		serotonin release in the small intestine and by blocking signals to the CNS. Ondansetron may also bind to other serotonin receptors and to mu-opioid receptors.	on temperature-regulating center in the hypothalamus by inhibiting synthesis of prostaglandin E2.	
Therapeutic Uses	Treat reflux disease.	To treat nausea.	Reduce fever. Relieve pain.	Reduce nicotine cravings and withdraw symptoms.
Therapeutic Range (if applicable)	N/A	N/A	No more than 1,000 mg in one dose. No more than 4,000 mg in a 24-hour period.	N/A
Reason Client Taking	To control GERD.	To treat nausea.	To treat pain associated with cervical stenosis.	Reduce nicotine cravings.
Contraindications (2)	Taking rilpivirine-containing products. Hypersensitivity to pantoprazole.	Concomitant use of apomorphine, hypersensitivity to ondansetron or its components.	Severe hepatic impairment. Severe active liver disease.	Life-threatening arrhythmias. Hypersensitivity to nicotine.
Side Effects/Adverse Reactions (2)	Abdominal pain. Angioedema.	Hypotension. Serotonin syndrome.	Agitation. Fatigue.	Hypertension. Headache.
Medication/Food Interactions	Avoid taking with milk products.	N/A	N/A	N/A/
Nursing Considerations (2)	Monitor urine output due to possible acute interstitial nephritis. Monitor for bone fractures due to the medication increasing the risk of osteoporosis.	Monitor client closely for serotonin syndrome. Monitor client closely for hypersensitivity to ondansetron because hypersensitivity reactions, including anaphylaxis and bronchospasms may occur.	Use acetaminophen cautiously in clients with hepatic impairment or active hepatic disease, alcoholism, chronic malnutrition, severe hypovolemia, or severe renal impairment.	Remove patch if patient is undergoing an MRI. Place patch on hairless, dry, and intact skin.

			Acetaminophen can cause hepatotoxicity, so liver function tests need to be ordered and monitored.	

Medications Reference (1) (APA):

Drugs.com. (n.d.). https://www.drugs.com/.

Jones & Bartlett Learning. (2019). *2019 Nurse's drug handbook* (18th. Ed.). Burlington, MA.

Mental Status Exam Findings (20 points)

APPEARANCE: **Behavior:** **Build:** **Attitude:** **Speech:** **Interpersonal style:** **Mood:** **Affect:**	**Clean, well groomed.** **Friendly, talkative, fidgets often.** **Medium build, client has lost weight.** **Pleasant attitude.** **Rapid, quick speech.** **The patient participated in interviews and was willing to talk.** **Pleasant mood.** **Alert, oriented. Actively participating.**
MAIN THOUGHT CONTENT: **Ideations:** **Delusions:** **Illusions:** **Obsessions:** **Compulsions:** **Phobias:**	**Patient admits to having suicidal thoughts in the past but currently is not having these thoughts.** **No delusions, illusions, obsessions, compulsions currently but does sometimes feel compulsions to self-harm.** **He states he doesn't think he has any phobias but prefers to avoid large crowds of people.**
ORIENTATION: **Sensorium:** **Thought Content:**	**Alert and oriented to person, place, and time.** **No sensorium.** **Thoughts seem to be unclear at some moments.**
MEMORY: **Remote:**	**Patient has a fair memory. Able to recall details of past admissions and doctor visits.**
REASONING:	**Currently seems to have fair judgement.**

Judgment: **Calculations:** **Intelligence:** **Abstraction:** **Impulse Control:**	**Calculations appropriate.** **Patient states he won't act impulsively.** **No abstraction.** **However, he does have cuts on his arm from previously acting impulsively.**
INSIGHT:	**The patient seems to have fair insight into current situation and why he is being hospitalized.**
GAIT: **Assistive Devices:** **Posture:** **Muscle Tone:** **Strength:** **Motor Movements:**	 **No assistive devices necessary.** **Good posture.** **Good muscle tone.** **Normal strength.** **Moves all extremities well.**

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
1400	72	125/79	16	97.4	97% room air
1830	75	138/87	16	96.8	98 % room air

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
1400	Numeric	Neck	2	Tingling	No interventions. Client states it is chronic due to cervical stenosis.
1830	Numeric	Neck	2	Tingling	No interventions. Client states it is chronic due to cervical stenosis.

Dietary Data (2 points)

Dietary Intake	
Percentage of Meal Consumed: **Breakfast:** 50% (Patient stated he ate about half this morning). **Lunch:** 100% **Dinner:** N/A	**Oral Fluid Intake with Meals (in mL)** **Breakfast:** 50% **Lunch:** 100% **Dinner:** N/A

Discharge Planning (4 points)

Discharge Plans (Yours for the client):

The patient's sister will pick him up from the hospital and take him home. He will continue receiving care by going to the Partial Hospitalization Program at OSF in Peoria. This will allow him to feel as though he has resources available to him when he needs them, but also ease back into a routine at home. He will also regularly meet with his therapist through OSF. The patient will also set up physical therapy to help his neck and back pain. The patient is going to work with his provider to continue testing out the right medication and dosage. He will take the medication as prescribed and not stop without contacting his provider.

Nursing Diagnosis (15 points)

Must be NANDA approved nursing diagnosis and listed in order of priority

Nursing Diagnosis • Include full nursing diagnosis with "related to" and "as evidenced by" components	**Rational** • Explain why the nursing diagnosis was chosen	**Immediate Interventions (At admission)**	**Intermediate Interventions (During hospitalization)**	**Community Interventions (Prior to discharge)**
1. Risk for hopelessness related to depression and anxiety.	The patient has anxiety that leads to him feeling hopeless and engaging in self-harming behavior.	**1.** The client should complete a suicide screening and assessment. **2.** Patient should be monitored often, and all items removed that the patient could use to harm himself. **3.** The patient should be presented with a consent for treatment.	**1.** The patient will attend group therapy service. **2.** The patient will meet with therapist one on one. **3.** The patient will maintain proper hygiene and oral care throughout his stay.	**1.** Patient will attend partial hospitalization during the day and return home in the evening. **2.** Patient will maintain medication regimen. **3.** The patient will reach out to friends when feeling depressed.
2. Risk for ineffective coping related to prolonged grieving of mother.	The patient's first mental health history began shortly after his mother died of cancer. He expressed that he is unable to move into acceptance that his mother passed away.	**1.** Assess the coping mechanisms the patient currently uses. **2.** Identify possible stressors that may trigger the patient to grieve. **3.** Monitor for signs of ineffective	**1.** Assess positive and negative coping mechanisms. **2.**Discuss effective ways to cope with grief such as journaling or reminiscing on good times with loved one. **3.** Assess the support systems the patient has in	**1.** The patient will discuss his grief and guilt he feels for his mother's passing with his therapist and group. **2.** The patient will not use self-harm as an outlet for his grief. **3.** The patient

		coping such as self-harm.	place.	will continue to use positive coping strategies such as writing in a journal or calling his sister.
3. Risk for chronic pain related to cervical stenosis.	Patient has chronic neck pain due to cervical stenosis. Chronic pain or illnesses can increase the risk of depression.	**1.** Assess musculoskeletal systems. **2.** Perform diagnostic testing such as a CT scan or MRI. **3.** Assess pain rating on a scale and administer pain medication as needed.	**1.** Review diagnostic procedure results. **2.** Consult with physical therapy while in the hospital setting. **3.** Continue to assess pain and administer pain medication appropriately, as needed.	**1.** Patient will attend physical therapy appointments. **2.** Patient will meet with physician to discuss all possible treatment options. **3.** Patient will attempt to get adequate rest and nutrition to fuel and heal his body.

Other References (APA):

Swearingen, P.L., & Wright, J.D. (2019). *All-in-one nursing care planning resource: medical-surgical, pediatric, maternity, and psychiatric-mental health.* St. Louis, MO: Elsevier.

Vera, M. (2019). *7 Anxiety and panic disorders nursing care plans.* Nurse Labs. https://nurseslabs.com/anxiety-panic-disorders-nursing-care-plans/.

Concept Map (20 Points):

Subjective Data

The patient stated that he was not currently having suicidal ideations. He expressed that he uses self-harm to deal with his anxiety and depression but doesn't want to commit suicide. He states that he is motivated to continue therapy and PHP in order to return to work soon.

Nursing Diagnosis/Outcomes

Risk for hopelessness related to depression and anxiety.
Outcome/Goal: Continue to attend PHP and counseling. When feeling anxious or depressed reach out to a friend, family member, or hotline.

Risk for ineffective coping related to prolonged grieving of mother.
Outcome/Goal: Explore feelings of guilt and sadness related to his mother's death with his therapist. Use positive coping mechanisms such as journaling or hiking.

Risk for chronic pain related to cervical stenosis.
Outcome/Goal: Decrease pain and increase physical function by attending physical therapy and exploring treatment options with physician.

Objective Data

Height: 5'6" Weight: 190 lbs
BP: 125/79 Pulse: 72 RR: 16
Temp: 97.4
O2: 97% on room air.

Vitals stable. Visible cut marks on left wrist. Patient moves and changes position often. Patient appears well-groomed.

Patient Information

44-year-old male. Admitted on 3/27/21.
Diagnosis: Unspecified depressive disorder, general anxiety disorder, and bipolar affective disorder. Patient is a full code. History of involuntary movement disorder, asthma, gastroesophageal reflux disease, high blood pressure, hyperlipidemia, and sleep apnea.

Nursing Interventions

The client should complete a suicide screening and assessment. Patient should be monitored often, and all items removed that the patient could use to harm himself. The patient should be presented with a consent for treatment.
The patient will attend group therapy service. The patient will meet with therapist one on one. The patient will maintain proper hygiene and oral care throughout his stay.
Patient will attend partial hospitalization during the day and return home in the evening. Patient will maintain medication regimen. The patient will reach out to friends when feeling depressed.
Assess the coping mechanisms the patient currently uses. Identify possible stressors that may trigger the patient to grieve. Monitor for signs of ineffective coping such as self-harm. Assess positive and negative coping mechanisms. Discuss effective ways to cope with grief such as journaling or reminiscing on good times with loved one. Assess the support systems the patient has in place.
The patient will discuss his grief and guilt he feels for his mother's passing with his therapist and group. The patient will not use self-harm as an outlet for his grief. The patient will continue to use positive coping strategies such as writing in a journal or calling his sister.
Assess musculoskeletal systems. Perform diagnostic testing such as a CT scan or MRI. Assess pain rating on a scale and administer pain medication as needed.
Review diagnostic procedure results. Consult with physical therapy while in the hospital setting. Continue to assess pain and administer pain medication appropriately, as needed. Patient will attend physical therapy appointments. Patient will meet with physician to discuss all possible treatment options. Patient will attempt to get adequate rest and nutrition to fuel and heal his body.